

NEWBORN SCREENING LAB SLIP
HOSPITAL/HEALTH DEPARTMENT COLLECTIONS

**IF LAB SUBMITS SPECIMEN WITH INCOMPLETE INFORMATION IT WILL BE
 REPORTED OUT AS INCOMPLETE INFORMATION**

**IT WILL BE THE RESPONSIBILITY OF THE HOSPITAL OF BIRTH TO LOCATE THE
 NEWBORN AND REPEAT SPECIMEN FOR SCREENING**

Instructions for completion of the Mississippi Department of Health Newborn Screening Lab Slip are as follows:

(ALWAYS check expiration date located on the far left side of the filter paper, next to the hour glass, noted by the year and date.)

() First Specimen All tests	() Home Birth	() Repeat Specimen	Reason: <input type="checkbox"/> <24 hr. <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Abnormal <input type="checkbox"/> Transfused <input type="checkbox"/> Inconclusive
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A. TOP LINE

1. **First Specimen All tests** - If it is the first newborn screening specimen collected on the infant, place an "X" in the blank provided.
2. **Home Birth** - If newborn was born at home, place an "X" in the blank provided.
3. **Repeat Specimen** - If the test is a repeat newborn screening specimen collected on the infant, place an "X" in the blank provided.
4. **Repeat Specimen Reason** - Put an "X" by the appropriate reason for a Repeat Specimen; < 24 hr, Unsatisfactory, Abnormal, Transfused, Inconclusive.

A N T S I N F O	Infant's Last Name		First	Previous Last Name	
	_____/_____/_____		(_____:_____) USE	(_____) 1. Single Birth	
	Birth Date		Time of Birth	Military Time Only (_____) 2. Twin () A or () B	
	_____/_____/_____		(_____:_____) USE	(_____) 3. Other _____	
	Date Collected		Time Collected	Military Time Only (_____) 3. Other _____	
Hospital of Birth Use Code		Hospital or H.D. Use Code		(_____) Medical Record Number	

B. INFANT'S INFORMATION - LEFT BLOCK PORTION

1. **Infant's Last/First Name** - Write infant's name in order as shown, making sure the name is spelled correctly. If the infant's first name is not available, put last name, followed by Boy/Girl. (Example: "Smith, Baby Boy")
2. **Previous Last Name** - If the infant's last name is different from the name given at birth, indicate the previous/original name in the blank provided. (NOTE: This applies to repeat specimens).
3. **Birth Date** - Write the date of birth using numbers only in the blank provided. (Example: December 25, 2002 will appear as 12-25-02)

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4. **Time of Birth** - Write the time of birth using MILITARY TIME ONLY in the blank provided. (Example: 2:30 p.m. will appear as 1430).
5. **Date Collected** - Write the time the specimen was collected using numbers only in the blank provided. (Example: December 2, 2003 will appear as 12-02-03)
6. **Time Collected** - Write the time the specimen was collected using MILITARY TIME ONLY in the blank provided. (Example: 8:00 p.m. will appear as 2000)
7. **Birth** - Write an "X" in the blank provided. (EXAMPLE: in the case of twins, an "X" would go on the no. 2 line with an "X" to indicate A or B).
8. **Hospital of Birth Code/Hospital or Health Department Collected Code** - Write the hospital code/health department code in the appropriate blank provided. NOTE: If the infant is born in the same hospital in which the specimen is collected, then both the hospital of birth code and hospital collected code will be the same. If the infant is born in one hospital, but transferred to another hospital prior to the specimen being collected, the hospital of collection code will be different from that of the hospital of birth. *When the specimen is collected/repeated by the Health Department, the Health Department county code is entered into the "Health Department collected" blank.*
9. **Medical Record Number** - Write the infant's medical record number in the blank provided.
10. **Physician's Name** - Write the name of the Physician who will be caring for the infant in the blank provided.
11. **Additional Information** - Use these lines to give the following information when:
 - infant is **ADOPTED** (give the name and address of the adoption agency, attorney or physician handling the adoption)
 - infant is **TRANSFERRED** to another hospital (give the name of the hospital where infant transferred)
 - infant **left hospital prior to newborn screening** being done
12. **Submitter Name/Address** - Write the name and address of the *hospital/health department* (submitter) in the blank provided.
13. **Specimen Collected By** - Write name or initials of person collection specimen in the blank provided.

SEX:	()	1. Male
	()	2. Female
RACE:	()	1. White
	()	2. Black
	()	3. Asian
	()	4. Am. Ind.
	()	5. Other
ETHNICITY:	()	1. Hispanic
	()	2. Nonhispanic

C. INFANT'S INFORMATION - MIDDLE BLOCK

1. **Sex** - Write an "X" in the appropriate blank provided.
2. **Race** - Write an "X" in the appropriate blank provided.
3. **Ethnicity** - Write an "X" in the appropriate blank provided.

S T A T E O F I N F A N T	Transfused:	()	Yes
	If yes		
	Date of Last Transfusion:	____ / ____ / ____	
	Gestation:	() Weeks	
	Birth Weight:	_____	Infant's Age Grams
	*Feeding:	() 1. Breast	() 2. Soy
		() 3. I.V.	() 4. Lactose
		() 5. TPN	
	Meconium ileus:	() Yes	() No

D. STATUS OF INFANT AT TIME OF COLLECTION - TOP RIGHT BLOCK

1. **Transfused** - If infant has been transfused PRIOR to the newborn screen being collected. write an "X" in the "YES" blank provided. and give the date and time of the last transfusion *using 6 numbers, no letters* in the blank. (Example: December 15, 2002 will appear as 12-15-02.)
2. **Gestation/Infant's Age** - Write the gestational age of the infant at the time of birth or the age of the baby at the time of collection in the blank provided.
3. **BIRTH WEIGHT** - Write the infant's weight in grams, AT THE TIME OF BIRTH in the blank provided.
4. **Feeding** - Write an "X" in the appropriate blank provided indicating the infant's feeding status at the time of collection. More than one blank may be marked.
5. **Meconium Ileus** - check the appropriate blank regarding the presence of a *meconium ileus*.

MOTHER'S INFORMATION			
Mother's Current Last Name		First	Mother's Date of Birth
Address			
City		State	Zip
(Phone)		Medicaid Number	
Mother's Social Security No.		(County of Resid.)	Use 2 Digit County Code

E. MOTHER'S INFORMATION - RIGHT BOTTOM BLOCK

1. **Mother's Current Last/First Name** - Write mother's full name in order, as specified at time of delivery in the blank provided. (**NOTE:** If the infant is to be ADOPTED, *do not* give mother's information. In the case of ADOPTION, this area should reflect the name of the agency, physician or attorney handling the adoption.)
2. **Mother's Date of Birth** - Write Mother's date of birth
3. **Address/Phone Number** - Write street number and name, (DO NOT GIVE P.O. BOX), Apt.#, as well as city, state, and zip code in the blanks provided. If the infant's parents have no phone, provide a neighbor's or family member's telephone number where a message can be received in the blanks provided. (**NOTE:** If the infant is ADOPTED, give the agency, physician or attorney name, address and phone number handling the adoption in the blanks provided.)
4. **Medicaid Number/Mother's Social Security Number** - Write Mother's Medicaid Number, if applicable, and Social Security Number in the blanks provided.
5. **County of Residence** - Write the county code where the infant lives: two digit number, i.e. Hinds County would be county code 25 in the blank provided. (**NOTE:** County code is the county of residence of the infant.)

Drop-Off Baby: In the event an infant is a "Drop-Off Baby" as a result of House Bill 169, assign the baby a name. The date the baby is left at the hospital is to be used as the date of birth, and the approximate time the baby was left is to be used at the time of birth, unless other information is known to the hospital. The hospital code is to be entered in the space provided for the hospital of birth and hospital collected. In the box provided for Physician's Name, note that this hospital is the emergency medical services provider. This will allow for adequate follow-up/tracking in the event of an abnormal or positive newborn screen.

Hearing Screen	
___ ABR	___ OAE
R Ear	L Ear
___ Pass	___ Pass
___ Refer	___ Refer

F. HEARING SCREENING

This section of the newborn screening form is to be completed by the hospital of birth prior to discharge. Check the appropriate test done, i.e. ABR/OAE, and the appropriate result for each ear, i.e., pass/refer. *If the hearing screening is not done, leave this section blank.*